IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 26, 2009

Tom Whittemore
Communicare, Inc #1 Gem
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #1 Gem, provider #13G008

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey of Communicare, Inc #1 Gem, which was conducted on June 22, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **July 8, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by July 8, 2009. If a request for informal dispute resolution is received after July 8, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

M. Williams

MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

CommuniCare, Inc.
40 West Franklin, Unit F
Meridian, Idaho 83642

Phone (208) 888-1155
Fax (208) 888-1156

Date: 7-15-2009 Time: _____ A.M./P.M. Fax #: 364.1888

To: Monica Williams, Surveyor

Subject: CCI#1 PDC

From: Tom Whittemore

Comments: Thanks for the extension

PRINTED: 06/25/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G008	A. BUILDING _____ B. WING _____	06/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #1 GEM	32 N GEM STREET NAMPA, ID 83651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations used in this report are: AQ - Assistant Qualified Mental Retardation Professional BMP - Behavior Management Program IPP - Individual Program Plan LPN - Licensed Practical Nurse LW - Lead Worker QMRP - Qualified Mental Retardation Professional	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain a record keeping system that contained accurate and complete information for 1 of 4 individuals (Individual #4) whose records were reviewed. This resulted in a lack of information being available to monitor an individual's day treatment programs. The findings include: 1. Individual #4's 6/12/08 IPP stated she was a 35 year old female whose diagnoses included mild mental retardation and a seizure disorder.	W 111	W111 Corrective Actions: Our permanent record system of documentation has locations for the types of documents mentioned but the specific responsibility of collecting this information could benefit from further clarification. Therefore the policy statement (see attached) which outlines procedure has been updated to include the expectation that these documents be obtained and appropriately filed. Identifying Others Potentially Affected: Records will be reviewed for all individuals at this location who attend Outside Services. System Changes: See "corrective actions".	7/13/2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 7-15-2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	Continued From page 1 Individual #4's record documented she attended a day treatment program on Monday and Tuesday, and a sheltered workshop Wednesday through Friday, each week. However, her record did not contain treatment plans, training programs, or progress reports from the day treatment program or from the sheltered workshop. When asked, the QMRP stated during an interview on 6/18/09 from 9:20 - 9:50 a.m., she would have to obtain the documents from the day treatment agencies. Without information related to Individual #4's day treatment plans, training objectives or progress reports to determine progression or regression, the facility would be unable to adequately monitor her day treatment programs. The facility failed to ensure Individual #4's record contained information related to her day treatment programs.	W 111	Monitoring: The QMRP will obtain necessary records and the QMRP Supervisor will check Permanent Records in August 2009 to insure they are filed. In addition the Quality Assurance review system will be scheduled on a semi-annual rather than annual basis and listed on the annual calendar to insure periodic reviews occur.	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure outside services were sufficiently coordinated and monitored for 1 of 1 individual (Individual #4) who attended outside day treatment programs. This resulted in an individual attending day treatment programs without the treatment team being aware	W 120	W120 Corrective Actions: Please refer to W111. In addition, inservice training will reoccur with this location's QMRP related to the attached policy statement regarding QMRP responsibility for monitoring outside services. Updated outside services binders will be prepared for all locations. For the next six months the frequency of contact with this location will be increased to monthly with narrative reports submitted to the QMRP supervisor for review.	8/22/2009

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W 120	Continued From page 2 of her training programs and related progression and/or regression. The findings include: 1. Individual #4's 6/12/08 IPP stated she was a 35 year old female whose diagnoses included mild mental retardation and seizure disorder. Individual #4's facility record documented she attended a day treatment program on Monday and Tuesday, and a sheltered workshop Wednesday through Friday, each week. However, her record did not contain treatment plans, training programs, or progress reports from the day treatment program or from the sheltered workshop. When asked, the QMRP stated during an interview on 6/18/09 from 9:20 - 9:50 a.m., she would have to obtain the above noted documents from the day treatment agencies. During an interview on 6/22/09 from 11:25 a.m. - 12:00 p.m., Individual #4's instructor at the sheltered workshop stated they did not send progress reports to the facility as they had not requested them. Further, Individual #4's records at the day treatment program and sheltered workshop were reviewed. The records showed Individual #4's IPP was dated 6/7/07 and her Monthly Nursing Summary was dated 8/07. Without information related to Individual #4's day treatment plans, training objectives or progress reports to determine progression or regression, the facility would be unable to adequately meet her day treatment needs.	W 120	Identifying Others Potentially Affected: Records will be reviewed for all individuals at this location who attend Outside Services. System Changes: See "corrective actions". Monitoring: See "corrective actions". In addition the Quality Assurance review system will be scheduled on a semi-annual rather than annual basis and listed on the annual calendar to insure periodic reviews occur.	

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W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each individual's need for guardianship was addressed for 1 of 4 individuals (Individual #2) whose IPP was reviewed. Failure to obtain guardianship did not ensure the individual's rights were protected. The findings include: 1. Individual #2's IPP, dated 6/19/08, documented a 56 year old female diagnosed with moderate mental retardation, major depression, schizophrenia, and Type II diabetes. Her medical record showed she routinely received Abilify (an antipsychotic drug) 5 mg a day for symptoms related to schizophrenia and Lexapro (an antidepressant drug) 10 mg a day for symptoms related to depression. Her IPP stated "[Individual #2] would benefit from having a legal guardian to help her protect her rights. Her sister would be the best person to assume the role of guardian ...But, for personal reasons has not pursued Guardianship [sic]." When asked, the QMRP stated during an interview on 6/18/09 from 9:10 - 9:20 a.m., Individual #2's sister did not want to be guardian	W 125	W125 Corrective Actions: Person #2 benefits from the active involvement, support and personal contact provided by her sister. The sister reviews and approves all plans , medical care and medications proposed for parson #2. To date there have been no adverse effects or out comes for person #2 as a result of not having a "Legal Guardian. When the prospect of becoming a legal guardian is raised the sister seems to feel distress and appears to feel caught between our desire for a legal guardian and the rest of the family's adverse feelings about guardianship. We view person #2's relationship with her sister to be vital to her continued well being. The family's concern may be partly cultural and informational in nature. We will reinitiate discussions with the sister about guardianship with the focus being to educate her about the potential impacts and implications of having or not having a guardianship in place. If she is willing we will arrange an appointment with an attorney at our expense to further discuss the matter. She is already aware that we have arranged to purchase guardianships for those individuals who need one but do not have guardians and who either cannot afford to pay for this process or whose family cannot afford to pay although this type of expense will not be a reimbursed cost. The family of this individual has had this issue discussed with them repeatedly	8/22/2009

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W 125	Continued From page 4 but did not want anyone else to be Individual #2's guardian either. When asked, the QMRP stated the facility was not pursuing guardianship for Individual #2. The facility failed to ensure guardianship was being pursued for Individual #2. Repeat deficiency.	W 125	but have chosen not to pursue this relationship. Perhaps with an educational approach progress can be made. It is important once again to note that person #2 with the consent and active involvement of her sister has received all needed services as needed. The QMRP /Administrator re initiate discussions on this subject and will document all contacts/progress regarding this issue.	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure adequate general and preventative medical care was provided to 2 of 4 individuals (Individuals #1 and #4) whose medical records were reviewed. This resulted in the potential for individuals health needs to not be met. The findings include: 1. Individual #1's IPP, dated 6/12/08, documented a 31 year old female diagnosed with severe mental retardation and Lennox-Gastaut Syndrome (a severe form of epilepsy). During an observation at the facility's day program on 6/15/09 from 12:40 - 1:35 p.m., Individual #1 was noted to be secured in a dining chair with a posy belt. When asked, staff working with Individual #1 stated the Posey belt was used to keep Individual #1 in her chair in case she had a seizure while eating lunch.	W 322	Identifying Others Potentially Affected: Records will be reviewed for all individuals at this location with a list of persons needing guardians given to the Administrator. System Changes: See "corrective actions". Monitoring: Administrator to make financial arrangements, QMRP to make monthly entries, QMRP Supervisor to do a review of QMRP Log as part of the scheduled Trending/Tracking process. W322 Corrective Actions: A protocol for use of the Posey for Individual #1 has been developed and the Dexa-Scan for Individual #2 has been completed. Others Affected: This is a rare situation and no other residents were affected by this or similar incidents. System Changes and Monitoring: In	7/13/2009

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W 322	Continued From page 5 During an observation at the facility on 6/16/09 from 6:30 - 8:15 a.m., staff were noted to use a posy belt to secure Individual #1 in her chair prior to eating breakfast. When asked, present staff stated the Posey belt was used to keep Individual #1 in her chair in case she had a seizure. When asked during an Interview on 6/18/09 from 9:10 - 10:10 a.m., if there were guidelines or a protocol in place for the use of the Posey belt, the QMRP stated there were none. 2. Individual #4's 6/12/08 IPP stated she was a 35 year old female whose diagnoses included mild mental retardation and seizure disorder. Individual #4's medical record documented that a Dexa-Scan test was recommended due to the prolonged use of seizure medications. However, her record did not contain evidence that the test was completed. When asked, the LPN stated during an interview on 6/18/09 from 9:25 - 9:50 a.m., it was not scheduled but would be "today." At 10:03 a.m. the same day, the LPN reported the Dexa-Scan was scheduled for July 30th. The facility failed to ensure Individuals #1 and #4 were provided with medical services as identified by their health needs.	W 322	the future the RN Supervisor will review Physician Progress notes each month during her monthly review in the home to further assure that any Physician recommendations that require an order are written and scheduled by the LPN.	

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MM168	16.11.03.075.07(a) Rights as a Citizen Rights as a citizen refer to all the rights of citizens of this country and any particular state or locality. These include, but are not limited to, voting, marriage, divorce, executing instruments (e.g., wills), acquiring and disposing of property, and choosing to practice or not practice a religion. This Rule is not met as evidenced by: Refer to W125.	MM168	MM168 Please refer to W125	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: 1. During an observation on 6/15/09 from 5:30 - 6:15 p.m., the following chemicals were noted to be unlocked in the facility's laundry room: - One container of bleach. - One container of Morning Mist disinfectant with a label stating "May be fatal if absorbed through the skin" and "Causes irreversible eye damage and skin burns." - One container of Bath Mate RTO with a label stating it may be harmful if absorbed through the skin. - One container of disinfectant spray with a label stating to avoid contact with eyes. A staff person, who was present at the time, was notified of the unlocked chemicals and stated they should have been locked.	MM271	MM271 1. Finding unlocked chemicals inside the home is very unusual. We have strict policies which require that chemicals be locked when not under the direct control of staff members. We will continue to follow our policy and will add periodic checks by the QMRP to be completed on a random basis at least once a month to further assure that the policy is being followed. 2. Finding unlocked chemicals outside is also very unusual, once again as stated above we have policies in place about the storage of chemicals. We will follow the procedure outlined above to further assure the policy is adhered to at all times.	7/13/2009

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-15-2009

STATE FORM 6899 F00D11 If continuation sheet 1 of 3

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MM271	Continued From page 1 2. An environmental review was conducted at the facility on 6/16/09 from 12:10 - 12:55 p.m. At that time, a one gallon container of Ortho Vegetation Killer was noted to be stored in an unlocked area in the back yard of the facility. A staff person, who was present at the time, was notified of the unlocked chemical and stated it should have been locked. The facility failed to ensure all toxic chemicals were kept under lock and key.	MM271		
MM537	16.03.11.210.01(b) Documentary Evidence Documentary evidence of the resident's progress and of his response to his habilitation program; This Rule is not met as evidenced by: Refer to W111.	MM537	MM537 Please refer to W111	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	MM735 Please refer to W322	
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation	MM859	MM859 Please refer to W120	

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MM859	Continued From page 2 Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859		